

First name	Surname		Date of birth (Day/Month/Year)
Street / Number		ZIP-Code	City
Mobile	E-Mail		Profession
Family doctor (name, street, mobile)			
Country and city of birth	Nationality	you speak?	
Reason for your visit today:			
Would you like us to inform	you about any specific top	ics or issues?	
,	, , . , . , , ,		
Would you like to be reminde	ed of the six-monthly check	-up? Yes No	
For females - are you pregnar	nt? Yes (wee	ek) No	
Infectious Diseases:			
HIV	AIDS	Tuberculosis	Hepatitis
Do you suffer from:			
Asthma	Osteoporosis		☐ Diabetis
Thyroid dysfunction / Th	nyroid gland disease		
General:			
Do you suffer from any blood	d diseases (thrombosis, le	ukemia)? Yes No	
Do you have a bleeding diso	·	,	
Do you have any circulatory		pressure)? low high	
Do you suffer from any hear	t diseases (heart valve/ hea	art rhythm disturbance/ heart	pass / heart attack/ stroke)?:
Do you suffer from any kidne			
Are you allergic to any subs	tances/materials?:		
Do you take any medicine re			lar)? If so, which ones?:
Do you have any other disea	ses or disablities not ment	tioned here? If so, which ones	?:

Do you smoke? Yes No			
Are you satisfied with the position/color/form o	of your, in short with you	rsmile? Y	es No
Is there interest in bleaching/whitening or profe	essional teeth cleaning?	Yes [No No
How did you become aware of us?:			
Referral Social med	dia	Google	Jameda
Other (please fill in):			
Many thanks for your cooperation!			
For reasons of simplification and acceleration, channel, notwithstanding the fact that interfere		_	
The patient is hereby informed that the custom processed with data processing equipment in signature I declare my consent and I have also	accordance with the law	and within the sco	ope of the contract. With my
Date	Signature		